MEDPAC Medicare Payment Advisory Commission

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Medicare hospital outlier payment policy

Medicare pays hospitals per-discharge rates that vary by category of inpatient case. Under this system, hospitals have a financial incentive to avoid extremely costly patients. To counter this incentive and promote access to hospital care for these extremely costly patients, Medicare makes additional payments, called outlier payments.

Overview of inpatient hospital payment

Medicare pays predetermined, per-discharge rates for 509 patient categories--called diagnosis related groups (DRGs)--to hospitals for inpatient care. These categories group patients with similar clinical problems who are expected to require similar amounts of hospital resources. For example, a patient who has a hip replacement would be in DRG 209: Major Joint and Limb Reattachment Procedures of Lower Extremity.

The payment rate for each DRG primarily depends on two factors: the relative costliness of the DRG compared with the average cost for all Medicare cases, and a national base payment amount adjusted to reflect the local input prices (nursing wage rates, for example) in the hospital's location. Each DRG has a multiplier, called a relative weight, that shows how average costs for that DRG compare to the national average cost. The relative weight for DRG 209 is 2.0782, so patients in this group on average use about twice the resources as the average Medicare patient.

In fiscal year 2003, the national payment amount for care furnished in large urban areas is about $4,251[1] (to simplify, we ignore the local market input-price level adjustment), so the national average payment rate for hip replacements (DRG 209) in these areas is:

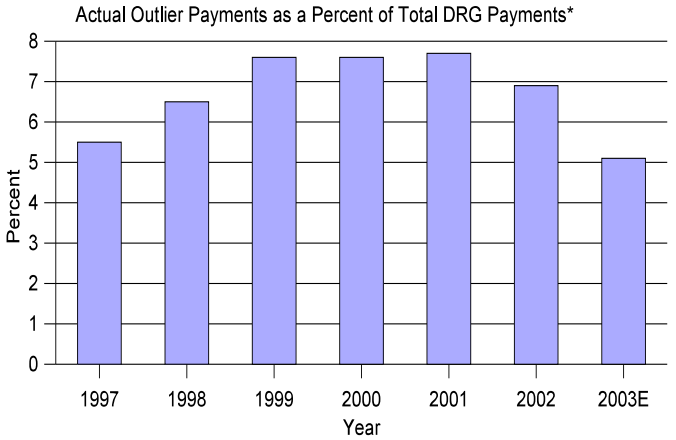
$4,251 * 2.0782 = $8,834

Extremely costly cases

Medicare payments vary by DRG, but hospitals' costs for cases within any DRG will vary among patients. Medicare expects that hospitals will offset losses on some cases (in which costs exceed the payment rate) with gains on others (in which costs are below payments). Some cases, though, are too costly to pay for through this mechanism.

The outlier policy addresses this problem and thereby promotes access to care for extremely costly patients who would otherwise be financially unattractive.

Medicare funds outlier payments by reducing the operating base payment amounts (5.1 percent) and the capital federal rate (5.3 percent). To limit outlier payments to these targets, Medicare sets a national fixed loss amount annually. Often, however, total outlier payments are higher or lower than anticipated (see chart below).



Source: CMS
*Total DRG payments=regular DRG payments+outlier payments

Medicare does not revisit the fixed loss amount to account for prediction errors, but uses past spending to improve the prediction for later years.

How to calculate outlier payments

The Medicare fiscal intermediary identifies outlier cases by comparing the estimated costs for a case to a DRG-specific fixed loss threshold. The threshold is the sum of:

- the DRG payment for the case
- any add-on payments for:
  - new technology,
  - indirect medical education,
  - disproportionate share of poor patients, and
- a fixed loss amount.

Like the national average base payment amount, the national fixed loss amount is adjusted to reflect hospitals' input prices in the local market. The national fixed loss amount for 2003 is $33,560; thus the threshold for DRG 209 for a hospital located in a large urban area is the sum of the fixed loss amount and the DRG payment:

$33,560 + $8,834 = $42,394[2]

Medicare pays 80 percent of hospitals' costs above their fixed loss thresholds.

Using Hospitals' cost-to-charge ratios

Because hospitals cannot calculate costs on a case-by-case basis, the fiscal intermediary uses the Medicare charges the hospital reported on its claim to estimate the cost of a case. The intermediary multiplies the covered charges by the hospital's cost-to-charge ratio (CCR) from the most recently settled cost report, which is often several years old.

For example, if patient charges for a case in 2003 were $300,000, and the hospital's most recent CCR (from 1999) was 0.2, then the implied costs for that case would be $60,000. The outlier payment would then be:

$60,000 - $42,394 = $17,606, then multiplied by .8 = $14,085

Substituting the state-wide average CCR

If hospital CCRs are very unusual for an area, the statewide average substitutes into the formula. When hospital CCRs are more than three standard deviations (plus or minus) from the statewide average CCR, the statewide average CCR is used to calculate implied costs and thus outlier payments.

Following the example of hip replacement above, assume that the hospital's CCR of 0.2 is more than three standard deviations below the statewide average. In this case, the intermediary would use the statewide average CCR (0.4 for example), and the estimated cost would be $120,000. The Medicare outlier payment would then be determined as follows:

$120,000 - $42,394 = $77,606, then multiplied by .8 = $62,085

If the hospital's CCR is more than three standard deviations above the statewide average, the estimated cost (and outlier payments) would fall.

This policy of substituting the statewide average when hospitals' CCRs were more than three standard deviations from the statewide average may raise or lower outlier payments substantially for particular hospitals. The policy, adopted in 1989, addressed a CMS concern at the time that "ratios falling outside this range are unreasonable and are probably due to faulty data reporting or entry. Therefore, they should not be used to identify and pay cost outliers."[3]

Endnotes

1. Includes the base payment amounts for operating expenses; does not include capital expenses.

2. Not adjusted for input-price level, or technology, indirect medical education, or disproportionate share payments.

3. Centers for Medicare & Medicaid Services. Medicare Program: Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1989 Rates, final rule, Federal Register. September 30, 1988, Vol. 53, No. 190, p. 38,503.

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